

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

Reg. Diat. No. 2810

12351

1. PLACE OF DEATH:

County St. Mary'sCity or town Rural Ridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Ridge (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Everline Wellford Abell

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White widowed

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

July 31 1855

8. AGE:

Years

Months

Days

If less than one day

9147

hrs.

min.

9. Birthplace Spotsylvania Va
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

FATHER
MOTHER

12. Name

Frank Tompkins

13. Birthplace

Virginia

14. Maiden name

Rebecca Turner

15. Birthplace

Virginia

16. Informant

Mrs Bayne Clark

Address

Ridge Md17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

12-7-46
(month) (day) (year)

Cemetery or crematory

Trinity Cemetery

Location

St. Marys City, Md

18. Funeral director

W. C. Mitterly & Son's

Address

Leonardtown Md19. 12-7
(Date rec'd by registrar)19-46pp Beary MD
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1946 at 12:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10, 1946, to Dec. 7, 1946and that I last saw him alive on Dec. 5, 1946

Immediate cause of death

General Anterior Sclerosis

DURATION

10 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

pp Beary MD

M. D. or other

Address

Great Mills MdDate signed 12-9-46

RECEIVED

DEC 10 1946

BUREAU V B

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

12352

Reg. Dist. No. 2020

1. PLACE OF DEATH: County <u>St. Mary's</u> City or town <u>Leonardtown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>3 days</u> Hospital, institution, or street address where death occurred: <u>St. Mary's Hospital</u> How long in hospital or institution? <u>3 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>St. Mary's</u> City or town <u>Mechanicville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>1</u> (If rural, give LOCATION) 2. (a) If veteran, name war <u>✓</u>	
3. (a) FULL NAME <u>James Briscoe Anderson Jr.</u>		3. (b) Social Security Number <u>✓</u>	
4. Sex <u>male</u>		5. Color or race <u>white</u>	
6. (b) Name of husband or wife <u>single</u>		6. (c) If alive, give age years	
7. Birth date of deceased (mo., day, yr.) <u>July 15, 1929</u>		8. AGE: Years <u>17</u> Months <u>0</u> Days <u>0</u>	
9. Birthplace <u>Maryland</u> (Town, county, and state)		10. Usual occupation <u>student</u>	
11. Industry or business <u>student</u>		12. Name <u>Briscoe Anderson</u>	
13. Birthplace <u>Maryland</u>		14. Maiden name <u>Cora Williams</u>	
15. Birthplace <u>Maryland</u>		16. Informant <u>James B. Anderson Sr.</u> Address <u>Mechanicville Md.</u>	
17. Burial (Burial, cremation, or removal. Which?) Date thereof <u>12-14-46</u> (month) (day) (year) Cemetery or crematory <u>St. Joseph</u> Location <u>Maryland</u>		18. Funeral director <u>A. B. Robinson</u> Address <u>Leonardtown Md.</u>	
19. 12/14 46 (Date rec'd by registrar)		20. DATE OF DEATH <u>December 11, 1946, at 9:15 P.M.</u>	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1946</u>		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>Accident</u> Date of <u>12-8-46</u> Where did injury occur? <u>near Leonardtown, Maryland</u> (City or town) (County) (State) Injured at home, farm, industry, public place (where?) <u>Highway no. 5</u> Means of injury <u>Automobile</u>	
23. SIGNATURE <u>J. F. Greenwell</u> Address <u>Leonardtown Md.</u>		24. SIGNATURE <u>Cora Williams</u> Address <u>Leonardtown Md.</u>	

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1946, at 9:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946and that I last saw him alive on 1946Immediate cause of death Enter CraniolfractureDue to Automobile accidentDue to Automobile accidentOther conditions Automobile accident



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

12353

Reg. Dist. No. 2820

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.).....

8. AGE:

Years

Months

Days

If less than one day

53

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

19.

46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

1946

at

2:38 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

discovery

19.

at 3:00 P.M.

1946

and that I last saw him..... alive on

19.

Immediate cause of death.....

Congestive heart failure

Due to.....

90% body surface burned

Due to.....

Ignition of clothing from stove

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

12-26-46

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Home

Means of injury.....

Fire

Injured at work?.....

Yes

23. SIGNATURE.....

Francis F. Greenwell, M.D.

M. D. or other

Address.....

Leomard Hall, Md.

Date signed 12-26-46

UNITED STATES DEPARTMENT OF HEALTH

INSTITUTIONAL REPORT

INSTITUTIONAL REPORT

RECEIVED
DEC 31 1946
BUREAU OF

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12354

Reg. Dist. No.

2820

1. PLACE OF DEATH:

County St Marys
City or town California md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year + 8 months
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County St Marys
City or town California
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Earl Hauptman Brown

3. (b) Social Security Number

579-32-5778

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced divorced

6.(b) Name of husband or wife Jessie Brown

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Aug 23 - 1895

8. AGE: Years 57 Months 3 Days 12 If less than one day hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation retired

11. Industry or business

12. Name Walter S. Brown

13. Birthplace Charles Co

14. Maiden name Minnie Hunter

15. Birthplace Alva Va

16. Informant Bayne Brown

Address 312 Webster St N.W.

17. Burial, cremation, or removal. Which? Burial Date thereof Dec 11 1944
(month) (day) (year)

Cemetery or crematory Congressional

Location Washington, D.C.

18. Funeral director W. C. Cunningham Sons

Address Leonardtown Md

19. 12/19 46 Cauley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1944, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from since its death on Dec 8 - 1944

and that I last saw alive on 19

Immediate cause of death hemorrhage

Other conditions self inflicted wound

Due to at left wrist

Due to entering both the radial

and ulnar arteries

Other conditions was heavy drinker at

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Dec 46

Where did injury occur? near California Springs Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Injured at work?

23. SIGNATURE Francis J. Greenwell M.D.

Address Leonardtown Md Date signed 12-8-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 11 1946

BURMA

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

12355

Reg. Dist. No. 2820

1. PLACE OF DEATH:

County St. Marys
City or town near Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County St. Marys
City or town Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

George Charles Combs

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 7 - 1874

8. AGE: Years 72 Months 9 Days 9 If less than one day hrs. min.

9. Birthplace Leonardtown St Marys Md
(town, county, and state)

10. Usual occupation farmer

11. Industry or business same

12. Name Charles Combs

13. Birthplace St Marys Co

14. Maiden name Jessie Stone

15. Birthplace St Marys Co

16. Informant Harry Combs

Address Leonardtown Md

17. Burial Date thereof Dec 18 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Our Lady chapel

Location near Leonardtown Md

18. Funeral director W. C. Mattingly Sr

Address Leonardtown Md

19. 12/17 St. Camillus
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1946 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1946 to Dec 16 1946 and that I last saw him alive on Dec 12 46

Immediate cause of death Cerebral Hemorrhage DURATION

Due to hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antemortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul A. Camillus M. D. or other
Address Leonardtown Date signed 12/17/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1946

BORSA

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 12356 2820

1. PLACE OF DEATH:

County St. Mary'sCity or town Gt. Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 monthsHospital, institution, or street address where death occurred:
Gt. Mills, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Louisiana CountyCity or town Shreveport
(If outside city or town limits, write RURAL and give nearest town)Street No. 232 Fairview St.
(If rural, give LOCATION)2.(a) If veteran, name war Anderson

3. (a) FULL NAME

GRIMES, Bryan Paul

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Single</u>

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6-13-23
6.(c) If alive, give age years

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>5</u>	<u>28</u>hrs.min.

9. Birthplace Crowley, Texas
(Town, county, and state)10. Usual occupation PhMc11. Industry or business U.S. Navy

FATHER	12. Name <u>Unknown</u>
	13. Birthplace

MOTHER	14. Maiden name <u>Mrs. Carrie Mae Grimes</u>
	15. Birthplace <u>Unknown</u>

18. Informant U.S. Navy
Address Patuxent River Md.17. Removal Date thereof 12-22-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Worth, Texas
Location18. Funeral director P.B. ROBINSON
Address Leonardtown, Md.19. 12/21/46 Registrar Canalier
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 19 46, at 3:45a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
on December 21 19 46, to 19and that I last saw him alive on 19Immediate cause of death Drowning DURATIONDue to Submersion after running off road into creek.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Drowning - Contusion to ileum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-21-46Where did injury occur? Gt. Mills, St. Mary's, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public HighwayMeans of injury Automobile accident Injured at work?23. SIGNATURE R.R. Bonar M.D.Address Francis Johnson Date signed Dec 21
Leonardtown and County

RECEIVED
DEC 24 1945
1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 948

CERTIFICATE OF DEATH

12357

Reg. Dist. No. 2860

1. PLACE OF DEATH:

County St. Mary'sCity or town Patuxent River
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County St. Mary'sCity or town Patuxent River
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sarah Lee Hill

3. (b) Social Security Number

4. Sex female 5. Color or race ed 6. (a) Single, married, widowed, or divorced6. (b) Name of husband or wife Charles Edward Hill

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) unknown 18898. AGE: Year 57 Months — Days — (If less than one day) _____ hrs. _____ min.9. Birthplace St. Mary's Co. md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name George Collins13. Birthplace md14. Maiden name Wm. F. Collins15. Birthplace md16. Informant Wm. F. CollinsAddress Patuxent River17. Burial, cremation, or removal, (Which?) Burial Date thereof 12-29-46
(month) (day) (year)Cemetery or crematory Patuxent RiverLocation Patuxent River18. Funeral director Wm. F. CollinsAddress Patuxent River19. 12-29-46 19 46 N. V. Salama
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 19 46 at 2a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-27-1946 to 12-29-1946and that I last saw him alive on 12-28-1946Immediate cause of death coronaryarteriosclerosisDURATION 10Due to long standingarteriosclerosisDue to long standingarteriosclerosisOther conditions coronary heart disease

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert P. Collins M. D. or otherAddress Patuxent River Date signed 12-29-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
JAN 2 1947
BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

Reg. Dist. No. 2820

1. PLACE OF DEATH:

County.....*St. Mary's*
 City or town.....*Leonardtown*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Mary's Hosp.

How long in hospital or institution?

3. (a) FULL NAME

Alice Jones

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb 14 1957

8. AGE:

Years

Months

Days

If less than one day

*89**9**17*

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Moans of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH *December 1* 19 *46* at *2:35* AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 30 19 *46* to *Dec 1* 19 *46*and that I last saw him alive on *Nov 30* 19 *46*

Immediate cause of death

Lobar pneumonia

Due to

Due to

Other conditions

Chronic myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Moans of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 8 1946

BUREAU V S

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

12359

★ Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
City or town Leonardtown md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 6 hours
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
City or town Harry
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war World War #2

3. (a) FULL NAME

John L. Mills

3. (b) Social Security Number

579-18-8308

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____ 5. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec 20 1920

8. AGE: Years 26 Months _____ Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Harry St. Mary's Maryland
(Town, county, and state)

10. Usual occupation Labor

11. Industry or business Labor

12. Name William H. Mills

13. Birthplace St. Mary's Co

14. Maiden name Mildred Young

15. Birthplace St. Mary's Co

16. Informant William H. Mills

Address Harry md

17. Burial Date thereof Dec 28 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart Cemetery

Location Bush wood md

18. Funeral director W. C. Mattingly Son

Address Leonardtown md

19. 12/27 46 Registrar Causey

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1946 at 8:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from one hour 30 min 19 46

and that I last saw h. _____ alive on _____ 19 _____

Immediate cause of death Internal Hemorrhage DURATION

and Peritonitis

Due to ruptured stomach

Due to and other internal injuries

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Contusion of Bladder +

Transverse Colon Rupture Date of op. 12-26-46

Autopsy results Stomach

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Automobile Accident Date of 12-26-46

Where did injury occur? One half mile N. Buchananville & Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Highway

Means of Injury Automobiles Injured at work? No

23. SIGNATURE Francis F. Howell M. D. or other

Address Leonardtown md Date signed 12-26-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 30 1945
FBI - NEW YORK

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-9

CERTIFICATE OF DEATH

12360

Reg. Dist. No. 282

1. PLACE OF DEATH

County St Marys
City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys
City or town Mechanicville
(If outside city or town limits, write RURAL and give nearest town)
Street No. A. H. D. St
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Harry S. Murphy
4. Sex Male 5. Color of face White 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Carolyn Herbert
6. (c) If alive, give age 31 years
7. Birth date of deceased (mo., day, yr.) Sept 17 - 1908
8. AGE: Years 38 Months 2 Days 20 It less than one day _____ hrs. _____ min.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 19 46, at 5-A AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 19 46 to Oct 29 19 46
and that I last saw him alive on Oct 25 19 46
Immediate cause of death Exhaustion of heart
DURATION 5 weeks
Due to acute alcoholism
Due to
Dth or conditions
(Include pregnancy within 8 months of death)

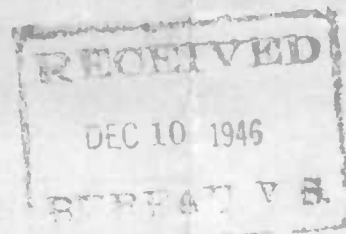
9. Birthplace Catonsville Charles Maryland
(Town, county, and state)
10. Usual occupation mechanic
11. Industry or business
FATHER 12. Name Lester Murphy
13. Birthplace Charles Co Md
MOTHER 14. Maiden name Agnes Duane
15. Birthplace St Marys Co
16. Informant Mrs. Carolyn H. Murphy
Address Mechanicville Md
17. Burial Date thereof Dec 9 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Johns Cemetery
Location Hoffman Rd Md
18. Funeral director W. C. Mathis & Son
Address Leonardtown Md
19. 12/8/46 Registrar Cummins
(Date rec'd by registrar)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Francis J. Greenwell M.D.
Address Leonardtown Md Date signed 12-6-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12361

Reg. Dist. No. 2820

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hra.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date reg'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

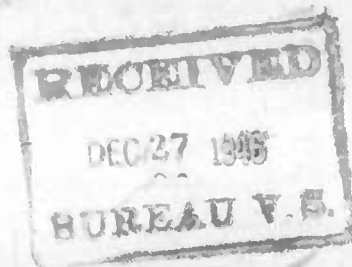
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12362

Reg. Dist. No.

2850

1. PLACE OF DEATH:

County St. Marys
City or town Leonardtwn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Marys Hospital

How long in hospital or institution?

1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys
City or town Hurry
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war World War LL

3. (a) FULL NAME

James Thomas Short

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of March 13 1925
deceased (mo., day, yr.)

8. AGE: Years 21 Months _____ Days _____ If less than one day
..... hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation chauffeur

11. Industry or business

12. Name William D. Short
13. Birthplace Maryland

14. Maiden name Mary E. Thomas
15. Birthplace Maryland

16. Informant Violet Barber
Address Pearson, Maryland

17. Burial Date thereof 12/ 28/ 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart
Location Bushwood, Md

18. Funeral director P.B. Robinson
Address Leonardtwn, Md.

19. 12/27 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 19 46 at 3:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....
and that I last saw him alive on Dec 26 19 46

Immediate cause of death Intercranial
Injuries

Due to automobile accident

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-26-1946

Where did injury occur? Michonievill & Mary and
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) State Highway 905

Mans of injury Automobile accident injured at work? No

23. SIGNATURE Francis F. Greenwell Coroner
M. D. or other

Address Leonardtwn, Md Date signed 12-27-46

RECEIVED
DEC 30 1946
BUREAU V B

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

12363

Reg. Diat. No. 2822

1. PLACE OF DEATH:

County St. Mary's
City or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 min
Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary's
City or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME

Infant Swales

3. (b) Social Security Number

4. Sex M 5. Color or race Cal 6. (a) Single, married, widowed, or divorced —

6. (b) Name of husband or wife

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 18/46

8. AGE: Years — Months — Days — If less than one day — hrs. 10 min.

9. Birthplace MD
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Chester Swales

13. Birthplace MD

14. Maiden name Elizabeth Swales

15. Birthplace MD

16. Informant Chester Swales
Address Leonardtown MD

17. Burial Date thereof Dec 19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John's

Location Hallwood Rd

18. Funeral director Chester Swales

Address Leonardtown

19. 12/19/46 Camden
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 46 at 2:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 46 to Dec 18 46 and that I last saw him alive on Dec 18 46

Immediate cause of death Pneumonia

DURATION

Due to —

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Paul A. Swales M. D. or other

Address Leonardtown Date signed 12/19/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 24 1946

STRAITS

1-35

Evidence for the change of
birth date is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

★ 12364

Reg. Dist. No. 2820

FILM No. I O 8 DEC 10 1946

1. PLACE OF DEATH

County St Marys
City or town Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys
City or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas Burton Thompson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Louise Russell Thompson

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) April 11 - 1908

8. AGE: Years 38 Months 7 Days 22 hrs. _____ min. _____

9. Birthplace Ave 15 Marys Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name W F Thompson

13. Birthplace St Marys Co

14. Maiden name Mary E. Herbert

15. Birthplace St Marys Co

18. Informant W F Thompson

Address Ave Maryland

11. Burial Date thereof Dec 5 1946
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Sacred Heart Cemetery

Location Bush wood Md

18. Funeral director W C Makins Inc

Address Leonardtown Md

19. 12/4 46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1946 at 5:45 P. M

I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1946 to Dec 3 1946 and that I last saw him alive on Nov 3 1946

Immediate cause of death gastric hemorrhage + shock

Due to Probably gastric ulcer

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank A. Cavallini M. D. or other _____

Address Leonardtown Date signed 12/4/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1946

BUREAU

1-35